

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVST4AGZ</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/13/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>AS TIME GOES BY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4710 NO CIMARRON ROAD LAS VEGAS, NV 89129</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted in your facility on 11/13/08.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.</p> <p>The facility was licensed for 10 total beds. The facility had the following category classified beds: 10 Category 2 beds</p> <p>The facility had the following endorsements:</p> <p>Residential facility for elderly or disabled persons Residential facility which provides care to persons with Alzheimer's disease</p> <p>The census at the time of the survey was 7. Seven resident files were reviewed and 7 employee files were reviewed.</p> <p>Complaint #NV00019879 - Substantiated (see Tag Y515)</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The following regulatory deficiencies were identified:</p>	Y 000		
Y 515 SS=G	449.259(1)(a) Supervision of Residents	Y 515		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 515	<p>Continued From page 1</p> <p>NAC 449.259 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary.</p> <p>This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary protective supervision for Resident #8 when toileting.</p> <p>Findings include:</p> <p>According to the medical records Resident #8, was admitted to the facility on 5/4/08 with a diagnoses of dementia. The physician's admission statement dated on 5/10/08, indicated that the resident needs assistance with toileting, bathing, dressing and protection against wandering.</p> <p>On 11/4/08, at 5:30 a.m. Resident #8 had an incident of a fall in the bathroom of the facility according to the incident report. The incident report indicated that on 11/4/08 at 5:30 a.m., Staff #1 took the resident to the bathroom, sat her on the toilet and told the resident to stay there. Staff #1 then left the resident unsupervised to get a diaper, the resident then got up, urinated on the floor, then slipped and fell hitting the back of her head. Staff #1 called 911 and the resident was transferred via ambulance to the emergency department of an acute care facility.</p> <p>The administrator indicated in an interview, that based on her investigation Staff #1 left Resident</p>	Y 515		

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Y 515	Continued From page 2  #8 alone for approximately one minute on the toilet.  According to the clinical report from the acute care facility, Resident #8 suffered a subdermal hematoma, subarachnoid hemorrhage, intracranial hemorrhage and laceration to the scalp. Resident #8 died on 11/8/08 at a hospice facility.  Complaint NV00019879  Severity 3 Scope 1.	Y 515		
Y 993 SS=D	449.2756(1)(d) Alzheimer's training  NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes the training and continuing education required pursuant to NAC 449.2768.  This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure each employee having direct contact with the residents, successfully completes training for care of Alzheimer residents, within the first three months of employment.	Y 993		

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Y 993	<p>Continued From page 3</p> <p>Findings include:</p> <p>A review of Staff #2's personnel file revealed that he was hired as a caregiver at the facility on 2/25/08. According to the staffing schedule, Staff #2 works full time on the day shift with another caregiver. As of 11/13/08, Staff #2's file did not have any documentation regarding completion of training for residents with Alzheimer.</p> <p>Severity 2 Scope 1.</p>	Y 993		

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